APPEAL NO. 022330
FILED OCTOBER 30, 2002

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing (CCH) was held on August 22, 2002. The hearing officer determined that the appellant/cross-respondent (claimant) reached maximum medical improvement (MMI) on December 20, 2001, with a 7% impairment rating (IR) as assessed in one of the designated doctor's reports; and that the claimant had disability from November 17, 2000, and continuing through the date of the CCH.

The claimant appealed, asserting that "the most recent statement by the designated doctor" (in response to the claimant's deposition on written questions) was that he wanted to reevaluate the claimant and that the claimant was not at MMI. The respondent/cross-appellant (carrier) cross-appeals, contending that the hearing officer failed to consider the designated doctor's response to the carrier's deposition on written questions; that the claimant reached MMI on March 8, 2001, with a 0% IR; and that the hearing officer erred in finding that the claimant had disability after January 18, 2001. The carrier responded to the claimant's appeal, arguing against any further amendment to the designated doctor's report or reports. The record does not have a response from the claimant to the carrier's cross-appeal.

DECISION

Reversed and remanded.

The parties stipulated that the claimant sustained a compensable injury on _____; that the carrier's required medical examination (RME) doctor certified that the claimant reached MMI on January 19, 2001, with a 0% IR; and that the Texas Workers' Compensation Commission (Commission)-selected designated doctor on March 14, 2001, certified that the claimant reached MMI on March 8, 2001, with a 0% IR. The claimant had been released to return to work full duty by the RME doctor on January 19, 2001. In the meanwhile the claimant had changed treating doctors and the new treating doctor had referred the claimant to some other doctors which eventually led to the claimant having a cervical discectomy and fusion at C5-6 in June 2001. The surgery did not go through the second opinion process and was paid for through group health benefits because, as the claimant argued, the carrier had denied liability.

Because of the cervical surgery the Commission sent the claimant back to the designated doctor for a second evaluation. In a report dated December 20, 2001, using the Guides to the Evaluation of Permanent Impairment, fourth edition (1st, 2nd, 3rd, or 4th printing, including corrections and changes as issued by the American Medical Association prior to May 16, 2000) the designated doctor assessed a 15% IR with a stipulated December 20, 2001, MMI date. The Commission pointed out that the third edition should have been used (all the other doctors had used the third edition) and the

designated doctor in an addendum dated February 25, 2002, assessed a 7% IR from Table 49 (subsection II E) and commented:

> The patient has no radiculopathy as a basis of additional [IR]. His range of motion impairment in the cervical region was 24%. In my opinion, this is associated with his unnecessary use of a cervical collar for restriction of range of motion. There is no anatomical basis for a 24% impairment associated with a one level C5-6 fusion.

Nonetheless in a Report of Medical Evaluation (TWCC-69) dated March 1, 2002, the designated doctor certified MMI on February 25, 2002, with a 24% IR. This was agreed with by the treating doctor.

Because the carrier had disputed that the compensable injury extended to the cervical spine, a CCH was conducted on March 27, 2002, with this same hearing officer presiding. The hearing officer determined that the compensable injury "extends to the Claimant's thoracic, cervical herniated disc, and lumbar spine." That determination was affirmed by the Appeals Panel in Texas Workers' Compensation Commission Appeal No. 020872, decided May 13, 2002.

On a TWCC-69 dated May 3, 2002, the designated doctor certified MMI on December 20, 2001, with a 7% IR (referencing an incorrect date of exam of February 25, 2002). Although not entirely clear, apparently, the February 25, 2002, addendum report was attached as the narrative.

Both parties were allowed to take the designated doctor's deposition on written questions. The carrier asks questions about various portions of the doctor's reports and concludes with a hypothetical question asking the doctor to assume what the carrier believes the law to be. In a response dated August 6, 2002, the doctor answers "yes" to most of the questions. The claimant attaches some 21 documents to his four written questions asking the doctor if he wishes to reevaluate the claimant. In a response which the hearing officer notes was "on August 15, 2002, or thereabouts" the designated doctor replied to all the questions "wish to re-evaluate." The hearing officer in Finding of Fact No. 11 of this decision found that:

> The last valid certification of the designated doctor, to wit that Claimant reached [MMI] on December 20, 2001 with a 7% [IR], is not contrary to the great weight of the other medical evidence.

The hearing officer also commented that "[b]oth sides argued that a big threshold question is whether the neck surgery in June of 2001 was 'reasonable and necessary' . . . . [and] that the Hearing Officer was the appropriate person to determine 'reasonable and necessary' under the circumstances of this case." We disagree with the hearing officer's comment and the parties' agreement that the hearing officer should determine whether the June 2001 cervical surgery was "reasonable and necessary." In Texas Workers' Compensation Commission Appeal No. 020415, decided April 1, 2002,

we addressed this issue citing Texas Workers' Compensation Commission Appeal No. 991263, decided July 29, 1999 (Unpublished), which stated:

> the issue of whether or not treatment is reasonable and necessary for the claimant's compensable injury in the past or in the future is not within the jurisdiction of the hearing officer. The determination of what "health care is reasonably required by the nature of the injury" is a matter for the Medical Review Division of the Commission. Section 413.031(a); Tex W.C. Comm'n, 28 TEX. ADMIN. CODE § 133.305 (Rule 133.305). The determination of "benefit disputes" are adjudicated by the Commission's Hearings Division. Rule 140.1. A "benefit dispute" is one "regarding compensability or eligibility for, or the amount of, income or death benefits." *Id.*

Although the hearing officer ruled on a question beyond his authority, he also made determinations within his authority that the cervical herniation is part of the compensable injury. Whether the claimant is entitled to income benefits (disability) for the compensable injury is also within the purview of the hearing officer to resolve.

At the CCH both parties speculate what the designated doctor knew or did not know. The carrier argued that the doctor was not aware that the cervical spinal surgery had not been authorized under workers' compensation procedures. The claimant argued that the designated doctor did not have some recent medical reports available. Both parties argued the effect of the designated doctor's answers to the deposition on written questions; the carrier argued that the hearing officer had failed to give the answers sufficient weight ("to consider the . . . responses") and the claimant argued the response was that the designated doctor wanted to reevaluate the claimant. The hearing officer and the carrier address whether the responses to the deposition on written questions constitute responses "considered to have presumptive weight as it is part of the doctor's opinion" within the meaning on Rule 130.6(i). The carrier argues that the preamble to Rule 130.6(i) makes clear that it is the <u>opinion</u> of the designated doctor rather than the <u>report</u> of the designated doctor that has presumptive weight. We do not necessarily disagree with that argument, however we do point out that Rule 130.6(i) deals with responses to any Commission requests for clarification. We are mindful that the Commission approved the depositions on written questions however it is clear that on reading the questions both parties were stressing their respective positions rather than requesting clarification of the designated doctor's opinion.

Under the circumstances of this case it is hard to determine what the "last valid certification" was and what information the designated doctor had available to him. Further, the last communication in time from the designated doctor appears to be his request to reevaluate the claimant, a request which appears to be in the best interest of all concerned.

We reverse the hearing officer's decision on the MMI date, the IR, and disability and remand the case for the claimant to be reevaluated by the designated doctor

pursuant to his request. The designated doctor is to be given all the relevant information for his consideration to include the decision in Appeal No. 020872, *supra*, and he should be advised that the compensable injury extends to the "cervical herniated disc." The designated doctor may also be made aware of the fact that the cervical surgery was paid for through group health coverage rather than going through the workers' compensation second opinion process although that does not change the fact that the claimant's cervical herniated disc is part of the compensable injury. Upon receiving the designated doctor's report the parties are to be given an opportunity to comment on the report. The hearing officer will then make his decision on the issues before him including the disability issue.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Commission's Division of Hearings, pursuant to Section 410.202 which was amended June 17, 2001, to exclude Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code in the computation of the 15-day appeal and response periods. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

The true corporate name of the insurance carrier is **UNITED STATES FIDELITY AND GUARANTY COMPANY** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
800 BRAZOS
AUSTIN, TEXAS 78701.

_____
Thomas A. Knapp
Appeals Judge

CONCUR:

Judy L. S. Barnes
Appeals Judge

_____
Michael B. McShane
Appeals Judge